11.12.14

Valley Surgical Center
Pre-Operative Assessment

Name: _____ DOB: _____ Ht: _____Wt: _____

Planned Surgical Procedure: _____ Family Physician: _____

Do you take any <u>blood thinners</u> such as Aspirin, Coumadin, Plavix, Effient, Pradaxa, Lovenox, Aggrenox, or Ibuprofen? □ YES □ NO
If yes please list what **<u>medication and dose</u>**, and **<u>the date your last dose was taken</u>**: _____

Do you reside in a Nursing Home/Assisted Living Facility/Skilled Nursing Facility? Y / N
If yes, please provide Facility Name: _____

Do you live alone? Y / N
If yes, is there someone available to stay with you for the next 24 hours if necessary? Y / N

Do you have an Advanced Directive? Y / N If yes, was a copy given to the facility? Y / N

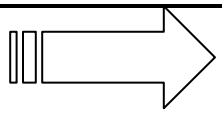
Have you fallen or been hospitalized within the last (6) months? Y / N
If yes, please describe _____

Do you have a history of: (circle all that apply)

<u>IF NOTHING HAS CHANGED WRITE SAME</u>

Cardiovascular	**Comments**	**Misc**
Heart Disease	_____	Renal/Liver failure
High Blood Pressure	_____	Hepatitis (A, B, C)
Pacemaker/AICD	_____	HIV/AIDS
Heart attack	_____	Thyroid Disease
Congestive Heart Failure	_____	Diabetes
Irregular heartbeat/A-fib	_____	
	_____	**Neurologic**
Respiratory	_____	Serious Head Injury
Asthma	_____	Seizures
COPD/Emphysema	_____	Stroke/TIA
Sleep Apnea	_____	
	_____	**Psychological**
Gastrointestinal	_____	Anxiety
Hiatal Hernia/Acid Reflux	_____	Depression
Crohns/Irritable Bowel	_____	Bipolar Disorder
	_____	
Hematologic	_____	**Urology/Nephrology**
Bleeding Tendency	_____	Incontinence
Anemia	_____	Kidney Stones
		Prostate Disease

Cancer (type): _____



11.12.14

List any surgeries or procedures you have had and when you had them:

(IF NOTHING HAS CHANGED WRITE SAME)

_____
_____
_____

Current Medication History

(List all that apply, including herbal supplements and over the counter medications)

If you have a list please give it to the healthcare provider, if there is not enough space to list all your medications please ask the receptionist for an extra sheet of paper.

IF NOTHING HAS CHANGED WRITE SAME

Medication	Dose	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies you have and your reaction: none: _____

_____
_____

Sensitivity to latex □ YES □ NO **Sensitivity to topical iodine: □ YES □ NO**

Have you or any of your biological relatives had a serious reaction to general anesthesia □ YES □ NO

Do you have any dental or oral appliances, loose or capped teeth or piercings? □ YES □ NO
If yes are they removable? □YES/□NO

Any possibility of pregnancy? □ YES □ NO When was your last menstrual cycle? _____

Name **Phone Number**

Individual that will be taking you home: _____ _____

Can we call you to follow up and see how you're feeling after the procedure? □YES □ NO
Best number to contact you at _____

Can we leave a message if you do not answer? □ YES □ NO

Can we speak to someone else if they answer? □ YES □NO

With my signature I acknowledge I have received a Pre-Procedure Instructions Sheet

Patient signature: _____ Date: _____

By signing below, VSC nursing personnel have reviewed and or updated the above information which is accurate and up to date: